

**MH THERAPIST
RENEWAL DEADLINE:
June 30, 2016**

RENEWAL QUESTIONS:

Questions regarding renewal should be directed to:

DMH Division of PLACE staff at
place@dmh.state.ms.us OR
(601) 359-1288.

**Mental Health Therapist Renewal 2016
Renewal Instructions**

-SUBMITTING THE RENEWAL PACKET-

1. **COMPLETE** the applicable form(s) listed below, along with your renewal fee payment:
 - Renewal Application Form – (**Two-Pages**; To be signed by the Renewal Applicant **IN BLUE INK** and dated) – pages 3 and 4;
 - Renewal Verification of Employment Form (**IF REQUIRED**-Refer to “Verifying Employment” below) - pg. 5;
 - **\$60.00 Renewal Fee** - payable by check or money order; DO NOT send cash; **MAKE CHECK/MONEY ORDER PAYABLE TO: MS DEPARTMENT OF MENTAL HEALTH**
2. **SUBMIT** your completed renewal packet (**including the renewal fee**) to the following address:

Mississippi Department of Mental Health
Division of Professional Licensure & Certification (PLACE)
239 North Lamar Street
1101 Robert E. Lee Building
Jackson, MS 39201

Attn: MH Therapist Renewal

- The completed renewal packet should be submitted as soon as possible, but **NO LATER THAN 5:00 p.m. on June 30, 2016**. Postmark dates are not considered; **only the date of receipt counts towards meeting the renewal requirement.**
3. **SUCCESSFUL RENEWAL** - Once successfully renewed, **you will receive a confirmation email** containing a renewal document which indicates continued certification/licensure for the next two-year certification/licensure period; in order to receive this email, **please include an email address on the Renewal Application Form**. Your Staff Development Officer(s) (SDO) will also receive an email confirmation of your renewal.

-IMPORTANT RENEWAL INFORMATION; PLEASE READ-

Verifying Continuing Education (CEs):

- Renewal continuing education (CE) hours are **NOT REPORTED AT THE TIME OF RENEWAL**. Sufficient documentation to this effect (e.g., training records; computerized staff development printouts; official college transcripts, if utilizing college credit) **should be housed with the Staff Development Officer (SDO) at your current place of employment**. *You should also keep a personal copy of your continuing education (CE) records.*

- If you are unsure who your program's designated SDO is, please contact the DMH Division of PLACE for assistance. (NOTE: If you change employment during a renewal cycle, it is your responsibility to provide your current SDO a copy of any training records from your previous place of employment that are needed to fulfill your renewal continuing education (CE) requirement.)
- A minimum of **30 continuing education (CE) hours accrued between July 1, 2014 and June 30, 2016**, is required to renew.
- If you obtained your CMHT credential after the beginning of the current certification/licensure period (July 1, 2014), you can still count appropriate CE hours which were earned prior to having received your credential, as long as these appropriate CE hours fall within the aforementioned time frame.
- Up to one-half of the required **30 continuing education (CE) hours may be obtained by presenting applicable training events.** Also, appropriate **graduate-level college credit** from an approved educational institution will be accepted to fulfill the continuing education (CE) requirement; one three (3) semester hour course (or its equivalent) is considered to equal 30 continuing education (CE) hours. If you are unsure whether or not a particular conference/workshop etc., will count towards your continuing education (CE) requirement, please have your Staff Development Officer (SDO) contact the Division of PLACE.
- The DMH Division of PLACE reserves the right to audit continuing education (CE) records of renewed individuals to determine compliance with the renewal continuing education (CE) requirement. If audited, you (in conjunction with your SDO) will be required to produce documentation to validate your completion of the renewal continuing education (CE) requirement. **Your signature on the Renewal Application Form denotes your understanding of this requirement.**

Verifying Employment:

- You only need to submit the Renewal Verification of Employment Form (page 5) with your renewal packet **IF your place of employment has changed.** If your place of employment has changed **AND** you have not already updated your employment information with the DMH Division of PLACE, then you need to include a completed Renewal Verification of Employment Form in your renewal packet. Otherwise, you do not need to submit this form.
- A change in "place of employment" refers to a change in your overall employer (agency/organization) **NOT** your specific job title.

-SPECIAL SITUATIONS DURING RENEWAL-

NAME CHANGE?

If your legal name has changed, and you have not yet completed the name change process with the DMH Division of PLACE, please follow the name change instructions found on pages 33 and 38 of the MH Therapist Booklet and submit your name change information along with your completed renewal packet. (The Mental Health Therapist Booklet is available online at the DMH website: www.dmh.ms.gov. Once on this website, click "PROVIDERS" then "PLACE." The booklet link is entitled, "Rules, Regulations & Application Guidelines/Forms & Updates for the Mental Health Therapist Program." **Your renewal packet will not be processed without submission of the appropriate name change information.**

CHOOSING NOT TO RENEW?

If you do not wish to renew, complete the appropriate section on the enclosed Renewal Application Form and return it to the DMH Division of PLACE at the address listed on Page 1.

-CHANGE TO LAPSED STATUS-

Renewal of professional certification/licensure is required on or before the **June 30, 2016, renewal deadline** in order to maintain "Current" status. **Failure to meet renewal requirements in a timely manner** will result in a change of status from **Current to Lapsed on July 1, 2016.**

MH THERAPIST RENEWAL APPLICATION FORM - 2016

-Personal Information-

1. Name: Mr. _____ 2. Social Security #: XXX - XX - _____
Ms. _____
Dr. _____ (Last 4 Digits)

3. Credential to be Renewed (check one):

Certified MH Therapist (CMHT)

Licensed Clinical MH Therapist (LCMHT)

4. Email Address: _____

(Email address is required)

COMPLETE Items 5-7 ONLY IF A CHANGE from your present listing with the Division of PLACE is desired; **your email address is required.**

5. Mailing Address: _____
(Street or P.O. Box)

(City)

(State)

(Zip Code)

6. Home/Cell Phone #: _____ 7. Work Phone #: _____

-Employment Information-

8. My current job title/position is: _____

9. I am currently employed at the following overall program/mental health center/agency/organization:

List the name of your Current Employer Here

10. CHECK **ONE** of the two (2) options below and follow the corresponding directions:

I **DO NOT** need to report a change in my place of employment. ("Place" of employment refers to your employer (agency/organization) **NOT** your specific job title.)

DO NOT submit a Renewal Verification Employment Form with your renewal packet; this form is only required if you are reporting a change in your place of employment.

I **DO** need to report a change in my place of employment. ("Place" of employment refers to your employer (agency/organization) **NOT** your specific job title.)

SUBMIT an updated Renewal Verification of Employment Form (**Page 5**) with your renewal packet to denote your change in employment; be sure and follow the directions on the form.

This is a **two-paged form.**
Renewal Applicant Must **Sign in BLUE INK** & Date Page 4



-Renewal Applicant's Statements of Assurance-

- RENEWAL APPLICANT MUST SIGN & DATE BELOW-

Directions: Read the "Renewal Applicant's Statements of Assurance" below. If you agree with the "Renewal Applicant's Statements of Assurance," print/type your full name and last four digits of your SSN in the designated space below, then sign below in BLUE INK and date the form. Failure to agree with these terms of renewal will delay and/or prohibit your ability to renew successfully.

-Renewal Applicant's Statements of Assurance-

I agree that I am the person who completed this application; that I am currently employed in the "state mental health system," as described in the *MH Therapist Booklet (Chapter 3); that I have met all continuing education (CE) renewal requirements and understand that my renewal CE records may be audited by DMH for compliance and that documentation to this effect must be housed with my organization's designated Staff Development Officer(s) (SDO); I agree that the statements contained in this Renewal Application are true in every respect; and, that I will conform to the Principles of Ethical and Professional Conduct of the Mississippi Department of Mental Health. *(The MH Therapist Booklet is available online at the DMH website: www.dmh.ms.gov. Once on this website, click "PROVIDERS" then "PLACE." The booklet link is entitled, "Rules, Regulations & Application Guidelines/Forms & Updates for the Mental Health Therapist Program."

Renewal Applicant's Printed/Typed Name: _____ **SSN:** XXX-XX-_____
(Last 4 Digits)

Signature of Renewal Applicant _____

*** (Signature in Blue Ink) ***

Date _____

-Individuals Choosing NOT TO RENEW (or Requesting Inactive Status)-

I **DO NOT** wish to renew my MH Therapist credential. I am returning this notice and request **ONE** of the options below (check one):

Retired Status;

Relinquished Status (Request must be accompanied by original wall certificate.);

Lapsed Status (Your credential will automatically Lapse on July 1, 2016, if you do not renew.)

*For more information about Retired, Relinquished or Lapsed Status or to determine your eligibility, please consult the *MH Therapist Booklet OR contact the Division of PLACE. *(The MH Therapist Booklet is available online at the DMH website: www.dmh.ms.gov. Once on this website, click "PROVIDERS" then "PLACE." The booklet link is entitled "Rules, Regulations & Application Guidelines/Forms & Updates for the Mental Health Therapist Program."*

CMHTs/LCMHTs interested in requesting Inactive Status should also consult this booklet or contact the Division of PLACE for more information; individuals granted Inactive Status must renew by the MH renewal deadline.

INCLUDE your Name and Social Security# on Page 3 of this form (along with any change of address, telephone number, etc.). **SIGN IN BLUE INK and DATE** this section only.

Signature **IN BLUE INK** (required)

Date

FOR OFFICE USE ONLY

Date Application Packet Received: _____

Last Four Digits of Applicant's SSN: _____

Date Application Reviewed: _____

PLACE Reviewer Initials: _____

☐ Completed Renewal Application Form ☐ A Check/MO for \$60.00. Date Received (If Received Separately): _____

☐ **AFTER June 30th** Late Renewal Fee Received - Date Received: _____

☐ Date Renewal Email/Mail Confirm Sent: _____ ☐ Date Problem Letter/Request for More Information Sent: _____

RENEWAL VERIFICATION OF EMPLOYMENT FORM

(To be completed by the Personnel Officer at the Renewal Applicant's current place of employment)

Directions: This form is to be completed by the **Personnel Officer** at the **Renewal Applicant's current place of employment**. Please type or print **ALL INFORMATION**; fill in every blank or check the appropriate boxes. Upon completion, **the Personnel Officer should seal the form in an envelope and sign his/her name across the envelope's seal**. The signature on the envelope should match the signature on the enclosed form. The Personnel Officer should then **return the sealed envelope to the Renewal Applicant** for submission to the Division.

1. Employment:

Renewal Applicant/Employee's Name & SSN	Renewal Applicant/Employee Name:
	Social Security Number: XXX-XX- _____ (Last 4 Digits)
Renewal Applicant/Employee's <u>Current</u> Place of Employment & Place of Employment (Physical) <u>Street Address</u>	Overall Agency/Organization/Program Name:
	Place of Employment (Physical) <u>Street Address</u> (Information must be included):
Renewal Applicant/Employee's Date of Hire (Only Report a Single Date of Hire)	_____/_____/_____ Month Day Year
Renewal Applicant/Employee's Job Title	

2. Background Check: (No one will be credentialed without proof of criminal background checks.)

As appropriate to the Applicant's position and professional responsibilities, have background checks been conducted regarding this Applicant? YES NO (Provide explanation)

Explanation: _____

3. State Mental Health System Qualification: (Check the appropriate qualification).

a. This applicant/employee **currently** works for an agency/organization which is **certified and/or funded** by the Mississippi Department of Mental Health. YES NO (Provide explanation)

b. This applicant/employee **currently** works for a program which is **operated/administered** by the Mississippi Department of Mental Health. YES NO (Provide explanation)

4. **Personnel Officer's Name:** _____ **Email:** _____
(Printed or Typed)

Signature of Personnel Officer

Date